

File as:  Worker's Compensation Cla	ılm	Date of Injury		Time of Injur	y 1	() a.m.	
O Incident Only Report		Supervisor's Date of Kno	wledge,		Civen to Emplo		O p.m.
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Employee's Name (Last, First)		EMPLOYEE IN	VFORMATION	Cell Ph	one.	Work Div	- Acces - Series Adjunction of the Series of
	and the state of t				1	Work Phon	e l
Department S	· ·	stadian, Sudger Intern	. 7	Em-"		*	_
Supervisor's Name	Superviso	or's Work Phone Supe	ervisor's Email			Supervisor's Fax	as
Hours Worked Per Week: Day	ys Worked: M-F	S M T W Th	F S Sta	art time:	O a.m.	End Time:	O a.m.
			FORMATION				1 2
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Action Causing Injury			$  \lambda_i  $	100	) ' ' ' ' ' '	$ \psi,\gamma\rangle$	
Environmental				/	(		\
Contributing Object/Equipment	(1)(1)	(}()		***************************************	, .		. ,
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Describe in detail how the accident occur	rred (I.e. Emplo	Ace was obening a pox and	the box cutter \$	lipped laceratin	g his laft thurni	Worsening	11
the last two wer		M Dhusicia	. 1	exting w		, 0	( ) .
Didiniury occurron campus? Yes	No .	Cantput location where hije	ary occurred	<del>USIN N</del>	Vi not on car	npus, name & address	of site over
tile removed	0	PSFA Build			1,0000	JDD WIN	yw c
Name & contact information of Witness:	None	Was another person respon	nsible? Yes	No S	Were other	employees Injured?	Yes No
office for 2 well	1	Name & contact information	n of responsible		Were Camp	us Police notified?	O O Yes No
Did the employee miss any work related	to the state of	No Yes If yes, Dat	Marie to the the contract of t	her I and .			0 0
Dit the employee thiss any work related	to the injury r	No Yes If yes, Dat	e:	Time From:	To:		/
AA (I -   Tank		MEDICALIN	FORMATION				
Medical Treatment Required		Medical Facility	a Rees-Stealy	If other, please		following:	1 A A
O None O Emergency Room O First Aid O Hospitalization	}	(O Othe	er	Physician/Faci Address:	lity Name:		
Medical Care	120 4011	<b>~</b>		Phone:			
(Pulmonology)	11 YUNUA	1 San Allerander					
Stipervisor's investigation: What action v	vill be taken to p	CORRECTI revent recurrence? Check	VE ACTION as many as appr	ropriate,			
Safety Guidelines Developed		Employee Counseled Sa	ifety	☐ P	ersonal Protec	tive Equipment Ordere	ed
Training Scheduled		Repairs Ordered			Other:	e Joseph .	on the annies of high days black community and approximate program of the state of
		<b>y</b> · · ·	~ N	1/11-		2/27	119
Completed By (Print Name)	1.8	Signature	,		olifilm gilgaland ang jaga aran kan pamal	Date	1 1 3

2/10/10 Dan 1172111



File as:  Worker's Compensation Claim	Date of Injury	Time of Injury	ious through	outende
(Ø) Incident Only Report	Supervisor's Date of Knowledge	Date DWC-1 Give	to Employee	C Pressor Cy
La contra de la contra del contra de la contra del l				16.20 (B.18.4-18.3) (F.16.4-
Employee's Name (Last, First)	### EMPLOYEE INFORMATION     Home Phone	. Cell Phone	Work Phon	
Department Job Title (I.a. Cu	stadian, Student Intern)	Emall	A service of the serv	,
Supervisor's Name Supervisor	or's Work Phone Supervisor's Email		Supervisor's Fax	~ 2015 (Ref)
Hours Worked Per Waak: Days Worked: M-I		t time:	i.m. End Time:	O a.m.
	INGIDENTINFORMATION			
trijured Body Part Mad / Luns		BACK OF HAND (circle injured part)	FRONT OF	
Type of Injury  Illnuss			As Marc	.nn.
Action Causing Injury	B S ( T ) B   MAN			
Furnes from Voot repair Contributing Object/Equipment				1
liblal	Left Left		ght Left	Right
Describe in detail how the accident occurred (i.e. Employers)	yee was opening a box and the box cutter sli Thing , when a			
Did injury occur on campus? Yes No	Campus location where injury occurred	1 16		
Ø 0	PSFA Building SI	254 "	ot on campus, name & address	of site
<b>M</b> .	Was another person responsible? Yes	<b>@</b>	are other employees injured?	Yes No
	Name & contact information of responsible	party? We	ere Campus Police notified?	Yes No
Did the employee miss any work related to the injury?	No Yes If yes, Date: T	lme From:	ro:	0 \$
Medical Treatment Required	MEDICAL INFORMATION			
	Sharp Rees-Stealy	r other, please com	olete the following:	
Mone © Emergency Room © First Aid © Hospitalization		hysician/Facility Na	me:	
O First Aid O Hospitalization  Medical Care		Address: Phone:		
Supervisor's Investigation: What action will be taken to p	GORRECTIVE ACTION (1999)	ndate		
`Safety Guidelines Developed	Employee Counseled Safety		al Protective Equipment Ordere	d
Training Scheduled	Repairs Ordered	Other:	Relocated to a	nother bul
, •••	t.		3/211	19
Completed By (Print Name)	Mgnature		B/21/19 Re	
1	E man from		3/21/19 Re	v. 4/23/14



#### SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury Please fax to 619-594-4013

File as: Worker's Compensation CI	alm	Date of Injury Jan. 31, 20	10	i	ime of Injury		Ø		
Incident Only Report		Supervisor's Date			10:00 Date DWC-1 G	iven to Emplo	⊚ a.n	1.	O p.m.
	dillinia di	Jan. 31, 20	19		2/2	6/A			
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Employee's Name (Last, First)		Home Phon	e		Cell Phor	ie	Work	Phone	~ ^ 4
Department	Job Title (I.e. C	ustodian, Student Intern)	**************************************		Email Email				
School of Public Affairs	) }		{						
Supervisor's Name	Supervis	or's Work Phone	Supervisor's E	mail			Supervisor's Fax	₹	***************************************
Hours Worked Per Week: Da	iys Worked: M		V Th F S	Start ti 08:0	<b>1</b>	) a.m. ) p.m.	End Time: 7:00	· · · · · · · · · · · · · · · · · · ·	() a.m.
		INCIDI	ENT INFORMA	TION					
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Other: Head				O	and together frames	æ,	(circie	lnjured part)	
Type of Injury	$\int_{\mathcal{A}} \tilde{\lambda} \tilde{\lambda} \tilde{\lambda} \tilde{\lambda} \tilde{\lambda}$		0,0	\[]]	6	11/9,	nMn,	Ma c	ln –
Other: Pain			11 1	V'V')	(3)	VV//	7001	/ <i>/// II</i>	(//
Action Causing Injury	<b>V</b> (1)	V W T	(b)	- 7	2 1	}	11		
Dust/Gas/Fumes/Vapors	) <sub>Y</sub> /\ <sub>Y</sub> (	)n/\n(	/		\	\ \ \	7-1	}	
Contributing Object/Equipment				Left		Right	Left		Right
Describe in detail how the accident occi	urred (i.e. Emplo	ovee was opening a ho	ay and the boy o	itter elinne	ad lacorating	ale left through			
Headache and vision issues poss a few days of headaches.									after
Did injury occur on campus? Yes	No	Campus location wh	ere injury occurr	ed		If not on carr	ipus, name & ado	tress of sit	· ·
•	0	PSFA							•
Name & contact information of Witness	: None	Was another person	responsible?	Yes N	lo	Were other o	employees Injure	d? Ye	
	Ī	Name & contact Info	rmation of respo	onsible par	rty?	Were Campı	is Police notified?		s No
Did the employee miss any work related	to the Injury?	No Yes If y	es, Date:	Time	e From:	To:			<i>,</i> 0
		O @ 2/	1/19	8	:00 a.m.	4:30	0 p.m.		
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Medical Treatment Required		Medical Facility	Sharp Rees-Ste	If ot	ther, please co	omplete the f	ollowing:	a_1, waa sir	
O None O Emergency Room			•	' '	sician/Facility	Name:			
O First Aid O Hospitalization Si Medical Care			Other	Add	iress:				
A Selfred Care				Pho	ne:				
		COR	RECTIVE ACTION	NČ					
Supervisor's investigation: What action v	will be taken to	prevent recurrence? (	Check as many a	s approprie	ate.		<del>- Oy nek más (kező s kenkentegy s jánneszesés könygyikye issze</del> szok		minute and and
Safety Guldelines Developed		Employee Couns	eled Safety		Pers	sonal Protecti	ve Equipment Or	dered	
Training Scheduled		Repairs Ordered			Oth	er: SUMAtr	ipan Succinat	e 25 MG	j
			K	7			3/20/19		
Completed By (Print Name)		Signature	<u> </u>		1	**************************************	Date	***************************************	

Z/20/. 5 Rev. 4/23/14



File as:		Date of Injury	0 2001	Time of Inju	Irv :			
Worker's Compensation Cla	aim	3	2-28-19	J. 11	(VV (1880)	(		m.q C
Incident Only Report		Supervisor's Date	of Knowledge		Date DWC-1 Given to Employee			→ h·III·
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						Work Pho	ne	** .44
Department	Job Title (Le. Cus	todian, Student Intern)	Pantin .	Email	***************************************			
Public Affaics	الماموري المام الداران	-			~	r 1	.Ji	
Supervisor's Name	Superviso	r's Work Phone	Supervisor's Email	L		Supervisor's Fax		
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Hours Worked Per Week: Day	ys Worked: M-F	SMTW	Th F S	Start time:	() a.m.	End Time:		P) 2 12
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old injury occur on campus? Yes	No C	ampus location whe	re injury occurred	**************************************	If not on camp	us, name & address	of site	
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lame & contact information of Witness:		/as another person r	esponsible? Yes	No	Were other on	iployees Injured?		
		•	O	Ø	Weie Odiel ell	thioxees injured?	Yes	No.
	N	ame & contact infor	mation of responsib	le party?	Were Campus	Police notified?	O Yes	No.
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First Ald Hospitalization  Medical Care  Jervisor's Investigation: What action will		MEDIC Medical Facility  CORR vent recurrence? Chemployee Counsel	AL INFORMATION Sharp Rees-Stealy Other ECTIVE ACTION Teck as many as appr	If other, please Physician/Facili Address: Phone:	complete the folkity Name:	lowing:		
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(C) Worker's Co	ompensation Claim	Date of Injury	Time of in	Hury = Za:30Am	<b>(')</b> s.m.	Op.m.
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) Dipartijent		(tè. Custodin, studer intern)	Email	<u> </u>		
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Name & rontact Infor	Ø O	ano. Was another person res	The state of the s	Ware other en	ployens injuted?	Yes No
		Name & contact inform	allin of responsible party?	Wero Campus	Police notified?	Yes No
Old the employee mis	s any work related to the tr	yuvy No Yes If yes,	Oate Iinie Fron	ne To:		<u> </u>
<u>Morlansia</u>	home today		(NEGRIMATION :			
ryonelli (etiillii) (e	Company of Alexander	resoul maneal comit / 094	If other, i	dease complete the fo /Facility Names	lowing	
O savio O	Emergency Room (Jospilalization	O.	Jither Addressi	24 (4) (22) (23) (24) (24) (24)		
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	tion What action will be to	ken to prevent recurrence? Ch	<b>预查货币等等的</b>	Dersonal Protectly		
<b>O</b> Vestal on 1		A SALEGER	Phone:			

#### SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

SAN DIEGO STATE
UNIVERSITY 2 6 3 17 19 Please fax to 619-594-4013

ile as: Worker's Compensation Clai	im	Date of Injury	9	Time of In		para () a.m.	87	<b>)</b> -p.m.
O Incident Only Report		Supervisor's Date		Date DW0	C-1 Given to Emplo			
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mployee's Name (Last, First)		Home Pho	OYEE INFORMATION		Phone	Work Ph	none	
and the second s					95175879333 and 14 and 1	-		
epartment   SFA	Job Title (i.e. Cu	ustodian, Student Intern)		Email	-			
upervisor's Name	Supervis	or's Work Phone	Supervisor's Ema	il		Supervisor's Fax	***************************************	
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ction Causing Injury	U(I)	V V 1	1	1700	7 1	171	1	7
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ontributing Object/Equipment	(1)(1)	()()		1	,			
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ork being done on the roof of PS						ing wha	led 1	04
			mout the			O		į.
id injury occur on campus? Yes	No		here injury occurred		7,50	npus, name & addr	ess of site	***************
id injury occur on campus? Yes	No				7,50	npus, name & addr	ess of site	
lame & contact information of Witness:	No O None	Campus location w	ng n responsible? Ye		If not on can	npus, name & addri	Yes	No
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ame & contact information of Witness:  YOU HIPLE OFFICE STREE  WAY IN WE SUMPTIME Id the employee miss any work related  Medical Treatment Required  None  O Emergency Room	No O None Syall	No Yes If O MED Medical Facility	n responsible? Yes Commation of responsives, Date:	Time From:  3  ON  Physician/F	Were other  Were Camp	employees injured? us Police notified?	Yes O Yes	O No
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ame & contact information of Witness:  AUTIPLE OFFICE STREE  AUTIPLE OFFICE STREE  AUTIPLE OFFICE STREE  AUTIPLE OFFICE  Bedical Treatment Required  None  First Aid  Hospitalization  Medical Care  Apervisor's Investigation: What action were	No O None  Sy a ( D S to the injury?	Name & contact in No Yes If O Medical Facility	n responsible? Yes formation of response  yes, Date:  Yes, Date:  OCAL INFORMATION  Sharp Rees-Steam  Other  ORRECTIVE ACTION  Check as many as a	Time From:    ON   If other, ple   Physician/F   Address:   Phone:   Phone:   Physician   Phone:   Pho	Were other  Were Camp  To:  asse complete the acility Name:	employees injured in us Police notified?	Yes Yes O	O No
ame & contact information of Witness:  YOU HIPLE OFFICE STREE  WOLL STREET STREET  WOLL STREET	No O None  Sy a ( D S to the injury?	Name & contact in MED  Medical Facility  Medical Facility	n responsible? Yes formation of response  yes, Date:  Yes, Date:  OCAL INFORMATION  Sharp Rees-Steam  Other  ORRECTIVE ACTION  Check as many as a	Time From:  ON  If other, ple  Address: Phone:	Were other  Were Camp  To: asse complete the acility Name:	employees injured in us Police notified?  (A)  following:	Yes Yes O	O No O
Isame & contact information of Witness:  Note the please of the Strict of the Employee miss any work related  Medical Treatment Required  None	No O None  None  SY A (	Name & contact in No Yes If O Medical Facility	n responsible? Yes of the responsible of the respon	Time From:  ON  If other, ple  Address: Phone:	Were other  Were Camp  To:  To:  To:  To:  To:  To:  To:  To	employees injured; us Police notified?  (A) (A) (B) (C) (C) (C) (C) (C) (C) (C) (C) (C) (C	Yes O  Yes O	No O
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ame & contact information of Witness:  NUMER OF LEST HE  WE SENTE OF  MALE SONTE OF  MILE SONTE	No O None None SY A ( D S None to the injury?	Campus location w PSFA Buildi Was another perso Name & contact in No Yes If O MED Medical Facility  CO prevent recurrence	n responsible? Yes of the responsible of the respon	Time From:  ON  If other, ple  Address: Phone:	Were other  Were Camp  To:  asse complete the acility Name:  Personal Protect  Other: MUHI	employees injured; us Police notified?  (A) (A) (A) (I) (I) (I) (I) (I) (I) (I) (I) (I) (I	ered to wo	O No O



File as:	Date of Injury	···	Time of Injury	**************************************	proprietation of the state of t	- The second
(*) Worker's Compensation Claim	Tues. Feb 26	I .	rime or injury Respira		O a.m.	<b>Ю</b> р.т.
🔊 Incident Only Report	Supervisor's Date of Knowledge	e ø		iven rownplo	·	W Hilli
	Truba Feb. 2(	6	2	26/19	ann a an anga ng hiji da da da na anga ng paga kana a ma	
	EMPLOYEE INFOR	MATION			THE STATE OF THE S	***************************************
Employee's Name (Lost, First)	Home Phone	and a specific	Cell Pho	ne	Work Phon	<b>e</b>
Department .   Job Title (i.e. cust	othan, Student Internj		[ Email		The state of the s	4. n.m.
PSFA		• •	1.11(0)		*	
	r's Work Phone Supervisor	r's Email		· · · · · · · · · · · · · · · · · · ·	Supervisor's Fax	
, ,		* .	<i>ታ</i> ግ -	(	Newscore Statement Consum	
Hours Worked Per Week: Days Worked: M-F	5 M T W Th F	S Start	time:	3) a.m.	End Time:	( ) a.m.
30   <u>X</u>			(	) p.m.	2.30	Ø p.m.
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lungs/nose		- (A		rC)	Pro eur tillatet	rgottj
Type of Injury		ALIA,	1 13	11/9 1	UUU ~ ~	MA
Respiratory Mill		ØVV)	/3	VV///	- /AMM //	7.11 (V)
Action Causing Injury		I' by	7 N	' <b>'</b> [	WILL	
building odor July		) /		(	7-1	\
Contributing Object/Equipment (1)(1)	())	, ,		, ,	, ,	, ,
	MM	Left	***************************************	Right	Left	01-1-1
						Right
Describe in détail how the accident occurred (i.e. Employ The building has had a	ee was opening a box and the bo	ox cutter slipp	ed lacerating	his left thumb	Pollis Vesto	er drei
it becarns very strong &	T ex Der 'elal oc	TO MALY	was by	SUM	other Add	THE
Did injury occur on campus? Yes No C	ampus location where injury occ	Curred	)	Hoot on carr	Due name & Adam	lingerec
M O	PSEA			in the dit out	pus, name & address	FF the bl
	Vas another person responsible?	Yes	No	111		***************************************
	sas another berault responsibles	athe.	νο ")	were other	imployees injured?	Yes No
1	lame & contact information of re			Were Campo	is Police notified?	Yes No
						O O
Did the employee miss any work related to the injury?	No Yes If yes, Date:	Tin	ie From:	To:	4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-	
	Ø O	######################################	Waller barren	CONTRACTOR OF THE CONTRACTOR O		
Service Company of the Company of th	MEDICALINFORM	ANTION A				
Miggil Trainnent negalren	Medical Facility	If c	ther, please o	omplete the f	ollowing:	ALMANA SASSA
None	Sharp Rees-		ysician/Facilit	y Name:		
O First Aid O Hospitalization	O Other	1	dress:			
Medical Care		Ph	one:			
	CANAGO ANT CARACTURA CONTRACTOR OF THE	V. 1. 2. 1. V. A. 6.3 W	4.64 1945 A	TRIVIN BUILDING		ng-quingen ng ay lawan bibbo men wasan ng mara-
A Control of Language Control of the Asset o	ZA ZORRECTIVE AC	TIÖN 🔝	Mar William	www.		
Sijjhjivisõr's investigation: What action will be taken to pr	event recurrence? Check as man	ıy as appropr	late.		A Separate S	The second secon
Safety Guidelines Developed	Employee Counseled Safety				ve Equipment Orderec	
Training Scheduled	Repairs Ordered		M-ou	er: Sewt	home	
and the second s			7	veloc	home aled on m	arch 4



File as:  O Worker's Compensation Claim	Jan 30-31, (eb 17, se)	Time of Injury	O a.m. O p.m.
M Incident Only Report	Supervisor's Date of Knowledge	AND DAY STREET STREET STREET	<b>→</b> • • • • • • • • • • • • • • • • • • •
	Jen. 30, 2019	1	
Fordoved's Name Back Elect	EMPLOYEE INFORMATION		ich darmit
,	Home Phone	Call Ahnna	- Work Phone
	usladian, Student interni	Email	
Abdic Afferrs/PSF7A			
Supervisor's Name Supervis	or's Work Phone Supervisor's Email	٠ ،	Supervisor's Fex
Hours Worked Per Weeki Days Worked: M		ort time: @ a.m.	End Time; O a.m.
Committee of the Commit	AS AS A JINCIDENT INFORMATION	40034664	
Injured Body Part	(circle injured part)	BACK OF HAND	FRONT OF HAND
		(circle injured part)	(circle injured part)
Type of Injury dissiness Within		A Alal	nna anna
headaches the		7 \*\\ <i>\\</i> }	(000) (000)
Action Causing Injury			2111/2
Furres )	)u)(a(		1-1
Contributing Object/Equipment	()()	1	
funes III	U Left	Right	t.eft flight
Describe in detail how the accident occurred (i.e. Emple			
formes related to moof	repairs have con	sed rousea.	elisanes & T
Did injury occur on campus? Yes No	Campus location where injury occurred		ous, name & address of site
· × o	PSF		, , , , , , , , , , , , , , , , , , , ,
Name & contact information of Witness: None	Was another person responsible? Yes		mployees injured? Yes No
_ [	Name & contact information of responsible	O Were Campu	Police natified? Yes No
,	unknopen		O Ø
Did the employee miss any work related to the injury?	•	Time From: To:	
Mark Charles and Assessment in the court of	Ø: O		<u> </u>
	##### #MEDICAUINFORMATION		
Medical Treatment Required	Medical Facility  Sharp Rees-Stealy	If other, please complete the fo	llowing:
None C Emergency Room O First Aid C Massimilation		Physician/Facility Name:	
O First Ald O Hospitalization O Medical Care		Address:	•
		Phone:	
	ACORRECTIVE ACTION		
isoperator sinvestigation: What action will be taken to	prevent recurrence? Check as many as appro	opriate.	on marine and the second secon
Safety Guidelines Developed	3 Employee Counseled Safety	Personal Protectiv	e Equipment Ordered
Training Scheduled	Repairs Ordered		acted on 3/11/19
	C		
			3/7/19
Completed By (Print Name)	Signature		Date

			444
O	Completed By (Print Name)	C Signature	3/7/19 Date 3/2/19 Rev. 4/23/14
	good grade with the grade of	· ·	3/1/17 Rev. 4/23/14



VACULA LICENTAL I	(-the	(ast month)			
File as:  ( ) Worker's Compensation Claim	2/26/19-2	127/19 HM of Inju	day	Q a.m.	O p.m.
Incident Only Report	Supervisor's Date of Knowle The Last new		Given to Emple	Aga?	713 14 14 14 14 14 14 14 14 14 14 14 14 14
Employee's Name (Last, First)	Hama Bhasa	anniga vert. La satt	1000 Iono	Work Phone	
Department Job Title (c.	o. Custodian, Studani Intern)	Emall &	er seenskad metakaran yayam magalanda sagam A	~	I management
PSFA	•			•	
Supervisor's Name Supe	rvisor's Work Phone Superv	Isor's Email	A A A A A A A A A A A A A A A A A A A	Supervisor's Fax	<del>a. Mar pagal gibigan gal 18 is salahag</del> pan <del>agi kadandan</del>
Hours Worked Per Week: Days Worked:	M-E S M T W Th	F S Start time:	② a.m. O p.m.	End Times	O n.m.
njured Body Part headaches noce burning	(drede injured part)	MONTH TO THE TANKS OF THE TANKS	io	FRONT OF H	Ø p.m.
Action Causing Induction				Si)	
Contributing Object/Equipment (1)(1	) ([[])		, ,	, ,	1 1
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ROUT NEP OUTS  CHUTCHE OFF.  Describe in datall how the accident occurred (i.e. En	playee was opening a box and the	box cultur sligned incorntly	ng his left thumb	***************************************	Right
Roof nepatricular like Cuuting off.  Describe in datali how the accident occurred (i.e. En gasarny — Romina	playee was opening a box and the Compus location where injury	e box stiller slipped lacerating the coldariance of	ng his left thumb	***************************************	
Describe in datali how the accident occurred (i.e. Englands and the control of the control occurred (i.e. Englands and the control occur on campus? Yes No O Name & contact information of Witness: None	Compus location where injury	e box cutter slipped lacerating the color occurred to the color oc	ng his left thumb		f site Yes No
Describe in datali how the accident occurred (i.e. Englands of Common Compus)  Did injury occur on campus?  Yes  O	Compus location where injury	e box culter slipped lacerath  Accide CAP  Occurred  ble? Yus No	ig his left thumb  I  If not on cam  Were other e	.) .pus, name & address o	F site  Yes No O Yes No
Describe in datali how the accident occurred (i.e. Englands and the control of th	Campus location where injury PS FA  Was another person responsil  Name & contact information of	e box culter slipped lacerath  Accide CAP  Occurred  ble? Yus No	ig his left thumb  I  If not on cam  Were other e	pus, name & address o	f site  Yes No O O
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Describe in datali how the accident occurred (i.e. Englished in datali	Compus location where injury PS FA  Was another person responsil  Name & contact information of  No Yes If yes, Data: O O  Medical Facility O Sharp R	e box culter slipped lacerath  A C C A C A C A C A C A C A C A C A C	Were other e Ware Campu To:	pus, name & address o employees injured? is Police notified?	F site  Yes No O Yes No
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Completed By (Print Name)

Signature

2/27/19 Date

3/19/19



File as:	····	Da	te of Injury			Tim	e of Injury	<del></del>				
Worker's Compensation C	.iami	OY	Ongolna Since December Supervisor's Date of Knowledge			<del>Maria da Maria da</del>		O a.m.	0	p.m.		
• Incident Only Report					edge	1911		126/19	λse	,,,,,,,		· · · · · · · · · · · · · · · · · · ·
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Employee's Name flast First)	emaddie i itteration tenski keliitiik	(415-1-11-11-11-11-11-11-11-11-11-11-11-11	EMPI.Ó Home Phon	YEE INFO	<u>ORMATIO</u>	1	Cell Phor			1 144 - 1 - 64	Widows were gasp.	
Childioass & Louise 11 act. 11 act.			Hume Phone	1			1 Cell Prior	ie		Work Phon	e	
Department	Job Title p.	u. Custodian,	Student lateraj			E	Emall	***************************************		<u> </u>	***************************************	
НТМ	•											
Supervisor's Name	Supe	rvisor's W	ork Phone	Supervi	isor's Email	<del>inciniosis d</del>			Supervi	sor's Fax	***************************************	***************************************
Hours Worked Per Week: C	ays Worked:	M-F	s m r w	) Th (		tart time 8;30	e: (	) p.m.	End Tin 5:00	10:	C	
	30,000	gripalita	incide	NT INE	inga katirak			( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )	33 (3)	10.00	3.77	***************************************
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Other: Head		~ ~			_ 0	(tircle	infored part)	Ø		(etrete Injure		
Type of Injury	N. I.	<u>``</u>			0/1/2	M	M			$\mathbb{W}_{n}$ $\alpha$	MA	
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Action Causing Injury	Uli	17	4/1	4	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Y	ا المريح			1 / /	17	
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Contributing Object/Equipment	· (')('	)	())		<b>'</b>			, ,			·	
Roof Work off gasing	\\.\!	(	MM		l.eft			Right	Lef	ì	Rigi	,
Describe in detail how the accident oc	district It at the			ماد ام مراد					<u> </u>		**************************************	
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There has been ongoing roof we that I begin to feel light headed a	and eventu	ally get a	paintul hea	dache.	Carle and War	280line	rumes.					trong
Did injury occur on campus? Yes	No		us location whe	ere injury	occurred			If not on can	npus, nar	ne & address	of site	
•	0	PSI		_								
Name & contact information of Witness	ss: None		nother person	-	Ø	No O		Were other	employe	es Injured?	Yes ①	No O
			& contact info		of responsit	le party	'7	Were Camp	us Palice	notified?	Yes	No
Did the employee miss any work relate	ed to the inter	/? No	asinic		<b>)</b>	70 b		and not may refer to the second		**************************************	0	0
,		yr INC		•	اسام	Time F	From:	To:				
Have been reteased	corry	<del></del>			28	<u> </u>			·····			Tree Horasson and property of the
	***************************************		MEDIC	AL INFO	RMATION		-					inger ige Tiller
Medical Treatment Required		Med	ical Facility	Sharo R	ees-Stealy	If other	er, please (	omplete the	following	<b>;</b>	, , , , , , , , ,	
None © Emergency Room	1		0	•		Physic	cian/Facilit	y Name:				
O First Aid O Hospitalization O Medical Care			O	Other		Addre	98 <b>5</b> ;					
O Medicar care						Phone	e:					
			100000000000000000000000000000000000000			<u>.                                    </u>		***************************************		Nonemanda - eranna mangara mangara yang 1994, ang	**************************************	
Supervisor's investigation; Whitegetion	will be taken	to preven	t recurrence? o	RECTIVE Theck as r	ACTION ntany as ap	propriate	e.	e sedudos, como selo, de historio de franças de	· ·		· · · · · · · · · · · · · · · · · · ·	
Safety Guidelines Developed		☐ En	nployee Counse	eled Safet	ty		Per	sonal Protect	ive Equir	oment Ordere	d	
Training Scheduled		RE	pairs Ordered				_	er: Sew		me,		
A CONTRACTOR OF THE PROPERTY O		7		4	_ł		¥	Kel	ocat	ea 3	HT9	
		$-$ \ $_{I}$	d						ار	مداره		
Completed By (Print Name)			Sjenature	1	"				Date	2015		
•		(	~ ^				****		3/	19/19 Re	v. 4/23/1	1
									•			



File as:		Date of Injury	**************************************	Time of Injur	у		
O Worker's Compensation	Claim	Jan. 2019 -	="	Ongoing O a.m.		O b.m.	
(3) Incident Only Report		Supervisor's Date of 1/17/2019	f Knowledge	1	Date DWC-1 Given to Employee 2/26/2019		
	• <del></del>		**************************************	<u> </u>	18		
Employee's Name (Last, First)		EMPLOY Home Phone	YEE INFORMATION	Cell Pho	one :	Work Phon	e
		N/A				1<114 (1991)	-
Department PSFA	Job Title (i.e. co	ustodian, Student Intern)		Email	-	***************************************	PRODUCTION OF THE PROPERTY OF
Supervisor's Name	Supervis	or's Work Phone	Supervisor's Email	1.		Supervisor's Fax	Warner Land Williams Linguistics
	1,					N/A	
Hours Worked Per Week;	Days Worked: M-			rt time:	(a.m.	End Time:	O a.m.
Harrist Commence of the Commen	V			00	O b.m.	5:00	<u> </u>
Injured Body Part		INCIDE (circle injured part)	<u>NT.INFORMATION 2</u>	BACK OF HANG		FRONT OF	HAND
Multiple Body Parts		$\Omega$		(circle injured part		(c)rcle injure	
Type of Injury	- (,, ,, ,)		P P	e s	1919	nnn.	Off o
Other:	1/1/2/1		1 18/1-19/	<i>5</i> ) (	W/19	/////// /	JWV
Action Causing Injury	- 47 ( 17)		4	100	} "	1211	1/2
Dust/Gas/Fumes/Vapors			"   ) /	<i>/</i>	(	1 }-1	1
Contributing Object/Equipment	-(1)(1)	$(\tilde{j})(\tilde{j})$	' '		, ,		. 1
Ongoing construction	ليالنا	A A	Left		Right	Left	Right
Describe in detail how the accident o	ccurred (I.e. Emplo	oyee was opening a bo	x and the box cutter sl	pped laceratin	g his left thumi	).)	**************************************
Inhalation of fumes, vapors, du difficulty breathing.	st, other air pa	rticles while existin	g in the building ca	ausing sever	e headache	s and respiratory is	ssues with
Did injury occur on campus? Yes	, No	Campus location whe	re injury occurred		If not on car	npus, name & address	of site
•	0	PSFA building	g		N/A		
Name & contact information of Witne		Was another person i		No	Were other	employees injured?	Yes No
Other PSFA building		Name & contact Infor	mation of responsible	party?	Were Camp	us Police notified?	Yes No
occupants		N/A	•	. ,			ÖÖ
Did the employee miss any work relat	ed to the injury?	No Yes If ye	es, Date:	Ilme From:	To:		
					475 XX XX 40504 X	Version de les voisies roues	
Medical Treatment Regulred		MEDIC Medical Facility	ALINFORMATION		complete the	following	
	**	1 .	Sharp Rees-Stealy		•	tollowing;	
None © Emergency Root O First Ald O Hospitalization	1)3	0	Othec	Physician/Facil Address:	ity Name:		
O Medical Care			į	Maaress; Phone:			
			0.0000000000000000000000000000000000000				N. P. L. P. L. STORY ST. ST.
Supardisor's investigations What action	n will be taken to	prevent recurrence? C	RECTIVE/ACTION :	opriate.		<u> </u>	i Mindifulla
Safety Guidelines Developed	-	T Employee Counse		dental	ersonal Protect	tive Equipment Ordere	d
Training Scheduled	ſ	Repairs Ordered	•		-44		
			Paddi. 11 6 6 6 1	<u>129</u> 10	Pelp	t horne	-119
					•	2/27/2019	



Completed By (Print Name)

Signatura

3/19/19 Rev. 4/23/14



File as:	Date of Injury	Time of Injury	**************************************
Worker's Compensation Claim	02/27/19	11 -40	® a.m. ○ p.m.
incident Only Report	Supervisor's Date of Knowledge	Date DWC-1 Given to Emplo	
		21261	[ ]
Employee's Name (Last, First)	EMPLOYEE INFORMATION	Cell Phone	
	Home ( nome	Cea Phone	Work Phone
,	todlan, Student Intern)	Email	д
PSFA		, ,	,
Supervisor's Name Supervisor	's Work Phone Supervisor's Email	4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	Supervisor's Fax
Hours Worked Per Week: Oays Worked: M-F	Name of the contract of the co	t time: 6 a.m.	End Time: O a.m. 4:30 @ p.m.
	INCIDENT INFORMATION	Edwin Elektrick College	
	ircle injured part)	BACK OF HAND	FRONT OF HAND
		(circle Injured part)	(circle injured part)
Type of injury	CIL) PA	9 9 19 19	000 000
coughing and Sinuses /		1 11/1/9	
EXACTION: Sevence Injury 27			2116
Environmental \			
Contributing Object/Equipment		, ,	
),)(	W W Left	Right	Left Pight
			Night.
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	inhalld by all bu		
NEW TOTAL AND	aminus location where inhiry accurred		npus, name & address of site
<b>©</b> 0	PSPA Bulding		demit the manifest of side
Name & contact information of Witness: None V	Vas another person responsible? Yes	No Were other	employees injured? Yes No
	O	0	employees injured? Yes No
N	ame & contact information of responsible p	party? Were Campi	us Police notified? Yes No
Did the employee miss any work related to the injury?	Ma Van Const Date		0 0
on the amproyed mass any work related to the injury?	O O	me From: To:	
Live of the Control o	MEDICALINFORMATION		
Middle Liegtwent Neonlied 3	Medical Facility	other, please complete the i	ollowing:
None O Emergency Room	Sharp Rees-Stealy P	hysician/Facility Name:	
O First Aid O Hospitalization O Medical Care	O Other	ddress:	
O laterital crass	р	hone:	•
	CORRECTIVE ACTION	Nga 15	
Supervisors investigation: Whattaction will be taken to pre	event recurrence? Check as many as approp	oriate.	20 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Safety Guidelines Developed	Employee Counseled Safety	Personal Protecti	ive Equipment Ordered
Training Scheduled	Repairs Ordered		
		Prother: Sent	scated 3 4 19
			Less (sed)
Completed By (Print Name)	Clauster	Maghaphana warranta in alam da da in alam da	2/2/1/14
Confinences by terror control	Signature		Date
		المستعدد المحادد	3/19/19 Rev. 4/23/14



File as:  Worker's Compensation Claim	Date of Injury	119	ime of Injury	O auth	<b>₿</b> ′p.m.
Incident Only Report	Supervisor's Date pl.Kno	wlades	ate DWC-1 Given to Emplo		)&) p.iii.
	Br V	. 1	- Jack 11	and free transcriptions about the control of the co	
Employeets Name II act (Street)	EMPLOYEE I	NFORMATIÓN	A-11-01		
	A MARKANIA	Eganos war pracum as	CelliPhone	- 75 - 1 Mork Phon	547
Department 10b Title	The the state of t	<del></del>	Email .		
10017					
Sup	ervisor's Work Phone Sup	ervisor's Email		Supervisor's Fax	***************************************
Hours Worked Por Week: Doys Worked		S Start th	Пре <u>В.</u> ім. р.іп.	End Time: 430	О а.т. Оф.т.
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Action Causing Injury		1 1		$\emptyset$ , $\gamma$	
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Contributing Object/Equipment	/ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	<u></u>			
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Describe in detail how the accident occurred (i.e. E	mployee was opening a box and	the box cutter slippe	d laçerating his left thurph	.) ,	
after being in	building	A 1 / 1 / 2	nenced	nard t	7 me
Old injury occur on campus? Yes No	Campus location where inju	ny occurred	If not on can	pus, name & address of	ATUN
Ø 0	100FA-BU	ildina		and the second second	JILC .
Name & contact information of Witness: Non	e Was another person respon	nsible? Yes No	O Were other a	mployees injured?	
		0 0	)	who where will 60%	Yes No
	Name & contact informatio	n of responsible part	ty? Were Campu	s Police notified?	Yes No
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Did the amployee miss any work related to the inju	y? No Yes If yes, Dat  O   O   O	124/19	From: To:	30	160 th
	MEDICALIN	FORMATION			National Control
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O First Aid O Hospitalization	O Othe	r Addı			
Medical Care		Phor			
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(StipleWiser's Investigation: What action will be taker	CORRECT! to prevent recurrence? Check a	VEACTION	te.		
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	The state of the s		Relo	cated on 8	314/19
mily factor and the same and the contract of t	J	L.		2/26/19	7
Completed By (Print Name)	Signature			Date	
· · · · · · · · · · · · · · · · · · ·	•	***** **** ****		2/19/19/10	1/23/13



File as:	Date of injury	Time of Injury	4
Worker's Compensation Claim	2/26/2019		<b>(</b> ) а.т. ( <b>(</b> ) р.т.
(incident Only Report	Supervisor's Date of Knowledge	Date DWC-1 Given to Emplo	ууов
	2/20/2019	2/26	19
	EMPLOYEE INFORMATIO	Ń	The second secon
mployee's Name (Last, First)	Home Phone	Cell Phone	Work Phone
	7.4 447. Y	SAME	, variations
	(i.e. Custodian, Student Intern)	Email	
PSFA		e e e e e e e e e e e e e e e e e e e	A
upervisor's Name Su	pervisor's Work Phone   Supervisor's Emal		Supervisor's Fax
		3 4	. ~
ours Worked Per Week: Days Worked	: M-F S M T W Th F S	Start time: ( a.m.	End Time: O a.m.
2-0		Ø p.m.	p.m.
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ype of Injury	1/10 1/10		
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ction Causing Injury		10 W 1	181119
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ontributing Object/Equipment	)	······································	
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escribe in detail how the accident occurred (i.e. t			
escribe in datal now the accident occurred free, t	improves was opening a box and the box citte	r supped lacerating his left thumi	5.}
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Id Injury occur on campus? Yes No	Campus location where injury occurred	The section of the se	
		I it not on car	npus, name & address of site
Ø O	PSFA	1	might warman applying light angresses track could self it is beingt warmed
ame & contact Information of Witness: No		No Were other	employees injured? Yes No
<u>,                                    </u>		O DO NO	or Kazows. O O
•	Mame & contact information of responsi	bie party? Were Camp	us Police notified? Yes No
V	7,7		0 @
ld the employee miss any work related to the inju	ry? No Yes If yes, Date:	Time From: To: _	and the state of t
	<b>@</b> O		
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Notes Freshment Regulfed	MEDICAL INFORMATIO	If other, please complete the	
	Sharp Rees-Stealy	it other, please complete tile	toliowing:
None	Oother	Physician/Facility Name:	
First Ald O Hospitalization	O Other	Address:	
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na Statite Briggioge Micro Station	CORRECTIVE ACTION		
ligivisor's investigation. What action will be take	n to prevent recurrence? Check as many as ac	propriate.	William Control of the Control of th
Safety Guidelines Developed	Employee Counseled Safety	[ ] Bassaud bast	dua Egylesson a d
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ompleted By (Print Name)	Signature	-	Date 3/19/19 1/19/14
1			3/19/19 20014



Name & contact information of responsible party?   Were Campus Police notified?   Y	<b>O</b> p.m
Employee's Name   Lest, First   Supervisor's Work Phone   Supervisor's Email   Supervisor's Fax	angrijanin <del>i 1</del>
Supervisor's Name  Supervisor's Work Phone  Supervisor's Email  Hours Worked Per Week:  Up  Days Worked:  NF S M T W Th F S Start three  A.m. 47.30  Separation  BACK OF HAND  FROM TO HAN  Describe in detail flow the accident occurred (i.e. Employee was opening a box and the box cottor slipped locarating his left thrumb.)  FLYNOLS TO NOT I claim  FLYNOLS TO NOT I claim  Contributing Object/Equipment  Distributing Object/Equipment  Was another purson responsible? Yes No Were other employees injured? Yes  Nome & contact information of Witness:  None  Nome & contact information of responsible party?  Were Campus Polica notified? Yes  Nome & contact information of responsible party?  Were Campus Polica notified? Yes  Nome & contact information of responsible party?  Were Campus Polica notified?  Yes Interpolation of the properties of the Individual Startibution  Office Interpolation of Witness:  Nome & contact information of responsible party?  Were Campus Polica notified?  Yes Interpolation of the properties of the Individual Startibution  Other  Address:  Physical Properties Equipment Ordered  CORRECTIVE ACTION  Safety Guidelines Developed  Described in the Individual Startibution of Protective Equipment Ordered	· · · · · · · · · · · · · · · · · · ·
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Type of lolly your was served with the secure of the through the secure of the secure	
Singly Neadacha Insulation  Contributing Object/Equipment  Left  Left  Describe in detail flow the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)  Flurnes in but liding due to Constitution  Did injury occur on campus? Yes No Campus location where injury occurred  If not on campus, name & address of all PSFA  Name & contact information of Witness:  None  Was another person responsible? Yes No Were other employees injured? Yes No Were Campus Police notified? Yes No Obtain Welfall Treatment Required  Medical Treatment Required  Medical Facility  None  O Emergency Room  O First Aid  O Hospitalization  O Other  Medical Care  Medical Care  Medical Gare  Medical Facility  O Other  CORRECTIVE ACTION  Safety Guidelines Developed  Employee Counseled Safety  Personal Protective Equipment Ordered	
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Figure 5 in building due to contact information of Witness:  None    Campus location where Injury occurred   If not on campus, name & address of state	Right
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Did the employee miss any work related to the injury? No Yes If yes, Date: Time From: To:    Medical Treatment Required   Medical Facility   If other, please complete the following:	SK C
Medical Treatment Required  Medical Facility Sharp Rees-Stealy Physician/Facility Name: Address: Phone:  CORRECTIVE ACTION  Safety Guidelines Developed  Medical Facility Name: Address: Phone:	0 0
Sharp Rees-Stealy First Ald Hospitalization Medical Care  Other Address: Phone:  CORRECTIVE ACTION Spend/spr/sployesteation: What action will be taken to prevent recurrence? Check as many as appropriate.  Safety Guidelines Developed  Employee Counseled Safety  Physician/Facility Name: Address: Phone:	
Medical Care    Address:   Phone:	**************************************
Separal Spring loves (gotton What action will be taken to prevent recurrence? Check as many as appropriate.    Safety Guidelines Developed	T
Safety Guidelines Developed Employee Counseled Safety Personal Protective Equipment Ordered	
Training Scheduled Renairs Ordered #Ktm. Count to group 4	
Training Scheduled Repairs Ordered Prother: Sent home Repairs Ordered Pulocated 341	2
Signature Date	

2/19/19" .....



# SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS Complete this form in its entirety and submit within 24-hours of the injury Please fax to 619-594-4013

File as:  Worker's Compensation Cl	aim	Date of Injury ONGOIN	16 212719	Time of Inju	ιλ	() a.m.	O p.m.
incident Only Report		Supervisor's Date	of Knowledge	daradykči	2 2 2 6 11 4		Obum
	***************************************		3/4/1	1995 Turks	2/21/17		
Employee's Name (Last, First)		Home Phon		ON Cell Ph	one.	Work Pho	
Phonesters and the second seco		-	and the second s			i work Prior	ne
Department SUMS	100 Little (re	i. Custodien, Student Internț		[ Email			··· · · · · · · · · · · · · · · · · ·
Supervisor's Name	Super	vlsor's Work Phone	Supervisor's Ema	, <u>i</u>		Supervisor's Fax	<u>. )U</u>
Have Made 17 - 18 - 1	114 1			· .			
Hours Worked Per Week: Da	ys Worked:		V The s	Start time:	O p.m.	End Time:	O a.m.
			ENTINFORMATION				O p.m.
Injured Body Part	(G)	(circle injured part)	10.10.000	BACK OF HAN (chele Injured par		FRONT OF	HAND
				(a) -	. "	(circle injure	zri part)
Type of Injury			1929			MAR	vWV .
and the state of t			il lin		100 M	July 1	1111/
Action Causing Injury	7/1		A.		1 }	/)/	11/
GAS FUMES Contributing Object/Equipment	(1)(1)		/		///	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	
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FUMES CAUSIN					ig his left thumb.	1	
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Did injury occur on campus? Yes	No O	Carripus location who	ere injury occurred	ı	If not on cam	pus, name & address	of site
Name & contact information of Witness:		Was another person	responsible? Ye	es No	Wasa athau	mployees Injured?	Marries - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -
	D		e	ro	Meis cilidi s	mbiokees Winted.	Yes No
		Name & contact info	, ·		Were Campu	s Police notified?	Yes No
Did the employee miss any work related	to the injury	No Yes If yo	es, Date:	2UCTON Time From:	To:		0 0
		<b>O</b> O					
		MEDIO	ALINFORMATIC	N diam			
Medical Treatment Required		Medical Facility	Sharp Rees-Stealy	if other, please	complete the fo	ollowing:	areannine san yen een
O Nane O Emergency Room O First Ald O Hospitalization		ŏ	Other	Physician/Facil	ity Name:		
O First Aid O Hospitalization O Medical Care			Data	Address:			
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			REOTIVE ACTION				
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<b>A</b> '			475				
78		,	- L			2/27/	107

Signature

Date 2/10/10

Rev 4/33/14



100 B	Ingibentine or Marketine Injury occurre	Cell Phone  Email  Start time: 1,00 a.m. p.m.  BACK OF HAND (circle injured part)  Left Right  Atter slipped lacerating his left thum	Supervisor's Fax  End Time: 4:00 PM O a O F FRONT OF HAND (circle injured part)  Left Right
Employee's Name (Last, First)  Department Job Title (Lo. 1974)  Supervisor's Name Supervisor's Name Supervisor's Name Supervisor's Name Supervisor's Name (Last, First)  Type of Injury  Action Causing Injury Proceedings of Contributing Object/Equipment Procedure (Le. Employee in detail how the accident occurred (Le. Employee Did Injury occur on campus? Yes No	Ison's Work Phone  Supervisor's English in the box currence of the	Cell Phone  Email  Start time: 1:00 O a.m. p.m.  BACK OF HAND (dircle injured part)  Left Right  atter slipped lacerating his left thum  CEC(111) NOSE	Supervisor's Fax  End Time: 4:00 p (V) O a FRONT OF HAND (circle injured part)  Left Right  b.) The closest haven a Called Called
Employee's Name (Last, First)  Department Job Title (Lo. 16%)  Supervisor's Name Sup	Home Phone  Custodian, Student Intern)  Pisor's Work Phone  Supervisor's Er  A-F S M T W Th F S  (NGIDENTINFORMAT (circle injured part)  Toyee was opening a box and the box cu  Campus location, where injury occurre	Cell Phone  Email  Start time: 1,00 a.m. p.m.  BACK OF HAND (circle injured part)  Left Right  Atter slipped lacerating his left thum	Supervisor's Fax  End Time: 4:00 P (V) O o FRONT OF HAND (circle injured part)  Left Right  b.) There been having  (U) Cille
Department  JON 3  Supervisor's Name  Supervisor's Name  Hours Worked Per Week:  JO  Injured Body Part  Type of Injury  Action Causing Injury  LINVICO MCMILL  Contributing Object/Equipment  DISON ON QUOLITY  Did Injury occur on campus? Yes No  Name & contact information of Witness: None  Did the employee miss any work related to the injury?	Custodian, Student Intern)  Ison's Work Phone Supervisor's End.  A-F 5 M T W Th F S  NGDENT:INFORMAT  (christe Injured part)  Ioyee was opening a box and the box cut  Campus location where injury occurred.	Email  Start time: 1/00 a.m. p.m.  DACK OF HAND (dired injured part)  Left Right  Atter slipped lacerating his left thum	Supervisor's Fax  End Time: 4:00 P (V) O o FRONT OF HAND (circle injured part)  Left Right  b.) There been having  (U) Cille
Supervisor's Name  Hours Worked Per Week:  UC  Injured Body Part  Type of Injury  City Communication  Contributing Object/Equipment  PACO O' COULTY  Describe in detail how the accident occurred (i.e. Employee in Jury)  Did Injury occur on campus?  Yes  No  Name & contact information of Witness:  None  Did the employee miss any work related to the injury?	Joyee was opening a box and the box cu	Start time: 1700 a.m. p.m.  BACK OF HAND (circle injured part)  Left Right  Atter slipped lacerating his left thum	End Time: 4:00 PM O a  FRONT OF HAND (circle injured part)  Left Right  b.) There been having  (UCTITE
Hours Worked Per Week:  UC  Injured Body Part  Type of Injury  Action Causing Injury  Contributing Object/Equipment  ONC  CY CYC Medical  Did Injury occur on campus?  Name & contact information of Witness:  None  Did the employee miss any work related to the injury?	Ioyee was opening a box and the box cu	Start time: 1/00 a.m. p.m.  BACK OF HAND (circle injured perd)  Left Right  Atter slipped lacerating his left thum  CEC(11) (100 SC)	End Time: 4:00 PM O a  FRONT OF HAND (circle injured part)  Left Right  b.) There been having  (UCTITE
Hours Worked Per Week:  UC)  Injured Body Part  Type of Injury  Action Causing Injury  Contributing Object/Equipment  OSO OS QUOLITY  Describe in detail how the accident occurred (i.e. Employed injury occur on campus? Yes No  Name & contact information of Witness: None  Did the employee miss any work related to the injury?	Ioyee was opening a box and the box cu	Start time: 1/00 a.m. p.m.  BACK OF HAND (circle injured perd)  Left Right  Atter slipped lacerating his left thum  CEC(11) (100 SC)	End Time: 4:00 PM O a  FRONT OF HAND (circle injured part)  Left Right  b.) There been having  (UCTITE
Injured Body Part  Type of Injury  Action Causing Injury  Environment  Contributing Object/Equipment  Describe in detail how the accident occurred (i.e. Employee in detail injury)  Did Injury occur on campus? Yes No  Name & contact information of Witness; None  Did the employee miss any work related to the injury?	loyee was opening a box and the box cure.  Campus location where injury occurre	BACK OF HAND (circle injured pers)  Left Right  Atter slipped lacerating his left thum  CEC(111) NOSE //	FRONT OF HAND (circle injured part)  Left Right  b.) There been having  (UCille
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Type of Injury  Action Causing Injury  PIVICO Mendal  Contributing Object/Equipment  VISON O'N QUALITY  Describe in detail how the accident accurred (i.e. Employee in detail how the accident occurred (i.e. Empl	loyee was opening a box and the box cu  Shuff a  Campus location where injury occurre	BACK OF HAND (circle injured pert)  Left Right  etter slipped lacerating his left thum	Left Right b.) The been having
Action Causing Injury  PIVICO Metable  Contributing Object/Equipment  PISOS ON QUOLIFY  Describe in detail how the accident occurred (i.e. Employed in Jury)  Did Injury occur on campus? Yes No  Name & contact information of Witness: None  Did the employee miss any work related to the injury?	loyee was opening a box and the box cu  Stuffy a	Left Right  Atter slipped lacerating his left thum  CEC(111) NOSE //	Left Right b.) The been having
Action Causing Injury  PIVICO Menuful  Contributing Object/Equipment  VISOS O'S QUOLITY  Describe in detail how the accident occurred (i.e. Employed injury occur on campus? Yes No  Name & contact information of Witness: None  Did the employee miss any work related to the injury?	loyee was opening a box and the box cu  Stuffy a	itter slipped lacerating his left thum	b) Thee been havine
Contributing Object/Equipment	loyee was opening a box and the box cu  Stuffy a	itter slipped lacerating his left thum	b) Thee been havine
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Contributing Object/Equipment  Visco of Quality  Describe in detail how the accident occurred (i.e. Emp  O WAR CY CYC Specific Young occur on campus? Yes No  No  Name & contact information of Witness: None  Did the employee miss any work related to the injury?	loyee was opening a box and the box cu  Stuffy a	itter slipped lacerating his left thum	b) Thee been havine
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Describe in detail how the accident occurred (i.e. Employer)    Walth Carl Carl Carl Carl Carl Carl Carl Carl	loyee was opening a box and the box cu  Stuffy a	itter slipped lacerating his left thum	b) Thee been havine
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wandarandarindi hardan en .	MEDICALINFORMATI	ION If other, please complete the	followings
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🔿 Medical Care		Phone:	
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Training Scheduled	Repairs Ordered	Aother: <u>Relo</u>	
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J. C.			O la alia
Campleted By (Print Name)			· / // / / / / / / / / / / / / / / / /
	Signature		2/27/19 Date



File as:  - Worker's Compensation Cla	alm	Date of Injury 2/28/19		Time of Injur	•			
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Employee's Name (Last, First)		Home Phon	9	Call Ph	nne	Work Pho	16	**********
Department	Job Title (i.e. Cus	todian, Student Intern)	emilioneriphismus is.	Email		<u>i</u> i		~~~~
IMS	l	·						
Supervisor's Name	Superviso	r's Work Phone	Supervisor's Email			Supervisor's Fax	**************************************	<del></del>
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Did injury occur on campus? Yes	No 1	Campus location whe	re injury occurred		If not on cam	pus, name & address	of site	···
<b>©</b>	O   F	PSFA						
Nama & contact Information of Witness:		Was another person		No	Were other e	mployees injured?	Yes No	<u></u> )
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	'	and the second second	matter or respectable	: 1,011,11	Were Campu	2 Source DORNAGA	Yes No	
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		COR	RECTIVE ACTION				***************************************	
Supprisons in All Strategic Manager action v	vill be taken to pr	revent recurrence? C	heck as many as appr	oprlate.	***************************************	<u> </u>	Anthonorman de	·
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Completed By (Print Name)		Signature				Date		
Newson is			junior			3/19/19	v. 4/23/14	



# SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS Complete this form in its entirety and submit within 24-hours of the injury Please fax to 619-594-4013

File as:	<del></del>	**************************************	Date	of Injury		Mungaria	Т	Tima	of Injury	*	,	······································		
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<ul> <li>Incident Only Report</li> </ul>				arvisor's Date		edge				Given to Emplo	уее		an in its later than the skip	***************************************
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Employee's Name (Last, First)		• • • • •	<u> </u>	Home Phone		ORMÁTIC	DN	<del></del> -T	Cell Pho	Ann	·	Work P	<u> </u>	
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Supervisor's Name		Supervis	ar's Wo	rk Phone	Superv	/isor's Ema	11		······································		Supervi	sor's Fax		10 tables 14
Hours Worked Per Week: 24 (in office/class)	Days W	orked: M-	F 5	MTW		F S		t time:	,	n.m.	End Tim			O a.m.
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Old-folusy occurs on campus? Ye	) )	No O	Campu PSF	s location whe	re injury	occurred /	<del>)</del>			If not on car	npus, nan	ne & addi	ress of site	·· — 44WB/#
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AT M		F4	Name 8	& contact Info	mation	749	~		***************************************	Were Camp	us Police	notified?	Yes	O No
				struction				, ,	- 4 6 F F				0	0
Did the employee miss any work rela	ited to th	e injury?	No ③	Yes If ye	s, Date:		Ti	ime Fr	om:	To:			· · · · · · · · · · · · · · · · · · ·	***************************************
Medical Treatment Required			Medic	/MEDIC al Facility	ÄLINFO	DRMATIC		other	, please	complete the	following	:		
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O First Aid O Hospitalization				0	Other		1	mysicia Addres:		ty Name:				
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Date 3/11/19 Rev. 4/23/14



#### SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS Complete this form in its entirety and submit within 24-hours of the injury Please fax to 619-594-4013

Worker's Compensation Claim	Date of Injury	Time	of Injury		· · · · · · · · · · · · · · · · · · ·	
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Incident Only Report	#Supervisor's Date of Knowle Stavtad 114	edge (Cala	DW//A: Given to Employee	**************************************		
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Employee's Name (Last Firet)	Home Phone	UNIVIATION S.	Cell Phone	Work Phon	<u> </u>	
Department Job Title II.e	a. Custodian, Student Interni		HRING. 4	1. 1. 1651		
NSE-A 1 200 Hite I'm	i. Costodian, Student Internj	i si	hall			-
and the same of th	visar's Work Phone   Superv	/Isor's Email		pervisor's Fax		
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Hours Worked Per Week: Days Worked:	M-F S M T W Th I	F S Start time:	····	d Time:	C	) ອະກາ.
Managara da Santa da			O p.m.	<u>4:30</u>		) p.m.
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grismell/frimes carried	me Acadache	e outer supper is	selling his ren thumb.	Later, a	Spolen.	Pc
my thrantiant earl and Did injury occur on campus? Yes No	s melo		0 0		00	
	1 ' '		If not on campu	, name & address	of site	<del></del>
	POFA BELG Was another person responsit					
Name & contact information of Witness: None	Was another person responsib		Were other emp	loyees injured?	Yes	No
- Indiana	Name & contact information of	O <b>(4)</b> of responsible party?	Were Campus P	o allow the N	Yes	O No
ir.				,	Ö	Ö
-	? No Yes If yes, Date:	ASSESSED BURNESS OF THE PROPERTY OF THE PROPER				
Did the employee miss any work related to the injury	• •	Time Fro	om: To:			
Old the employee miss any work related to the injury	OO	Time Fr	om: To:			
New Page 18 Comment of the Comment o	O O	SRIMATION	Sa Markovico de Santa	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
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Sign

Date

3/19/180y. 4/23/14



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Incident Only Report	and the second of the second o	Jan/Feb 20		6averbwc-1	Glyen to Emplo	yee   21		
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Employee's Name (tast. First)		Home Pho	ine	Cell Ph	ione	Work Pho	ne	
Department I-ITM	Job Title (i.e. co	stodion, Student Intern)	was proposed to the special way of the proposed to the special	Emall				
Supervisor's Name	Supervis	or's Work Phone	Supervisor's Email			Supervisor's Fax	af yang big di di mananan digang sa unsu sapapan	
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Injured Body Part		circle injured part)	DENT INFORMATION	BACK OF HAN	D D	FRONT O	F HAND	159
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Type of Injury			[ 1720 ]	B (		$U(U)^{\alpha}$	aMa	•
irriation, headaches			W KAN.	7	(1.1.1.1)		1000	~~~
Action Causing Injury	V(1)	VVII			7 1		117	, mark
Chemicals in the air	}\{\\	)n/		/	/ /	1-1	1-1	
Contributing Object/Equipment		AA	Left		Right	Left	Right	7
Describe in detail how the accident occu	weedle Treelo	lean bloom was a lean and	<u> </u>					
The PSFA bullding has been unde me headaches, lichy and Irritated	er constructio	n for many mon	ths. For the last ma	onth there he	a hear toyle	emalling objects	h has give so bad,	ən
Did Injury occur on campus? Yes	No	Campus location w	here injury occurred	теления на намения	If not on can	ipus, name & addres	s of site	<del>••••</del> ••••••••
<b>©</b>	0	SDSU - PSF	EA .					
Name & contact information of Witness:		Was another perso	n responsible? Yes	No O	Were other e	employees Injured?		No O
	w —	Name & contact in	formation of responsibl	e party?	Were Campu	is Police notified?	Yes	No O
Did the employee miss any work related	to the injury?	No Yes If	yes, Date:	Time From:	To:	retor (nith stein d	helione and a second	<u> </u>
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Medical Treatment Required	1.344 (24)0688	Medical Facility	ICAL INFORMATION	If other, please	complete the f	allowing:		
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·		1				2/27	49	



Completed By (Print Name)

Signature



SAN DIEGO STATE UNIVERSITY		Please fax to 619	9-594-4013	Isi	dro (	ervante	5 ×411
File as:  Worker's Compensation Claim		03/04/2019		Time of injury		O a.m.	O p.m.
Incident Only Report		Supervisor's Date of Knowle	dge	Date DWC-1	Given to Employ	/ee	
		EMPLOYEE INFO	ORMATION	L		, , , , , , , , , , , , , , , , , , , ,	· · · · · · · · · · · · · · · · · · ·
Employee's Name (Last, First)		Red ID		Primary	Phone		<i>x</i> ~
Department Jos	Title (i.e. Custo	odian, Student interni	A	Email			
Supervisor's Name	Supervisor	's Work Phone Supervi	sor's Email	· f.J.		err ar a	
Hours Worked Per Week: Days W	orked: M-F			, ~	Ø a.m. p.m.	End Time:	O a.m.
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Name & contact Information of Witness:	None V	Yas another person responsib	ole? Yes	No Ø	Were other e	mployees injured?	Yes No
	۱.۸	lame & contact information o	of responsible	party?	Were Campus	s Police natified?	Yes No
Did the employee miss any work related to ti	he injury?	No Yes If yes, Date:	1	ime From:	To;		
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File as:	· ·	Date of injury	11 19 1		ne of Injury			
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Describe in detail how the accident occurred    Continued   Continued	None W Na he injury?	head ampus location who ps FA as another person	a Chas s Ty-e's ere injury occur responsible? ormation of resp	vitter slipped  S CAC  red  Yes No  O O  onsible party	usep	his left thumb	inpus, name & addressemployees injured?	yes No C
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Did injury occur on ampus? Yes  Name & contact information of Witness:  Did the employee miss any work related to the Medical Treatment Required  O None  O Emergency Room	None W Na he injury?	ampus location who was another person ame & contact info  No Yes If you would be a second ame with the sec	responsible?	Yes No O Oonsible party Time TION Physi Addro Phon	From: er, please of clan/facility ess: e:	were other to the complete the invariant of the complete the complete the complete the invariant of the complete the c	inpus, name & addressemployees injured?	Yes No C



File 95: (7) Worker's Compensation Ch	alm	Date of Injury 2/19/2019	ero (autorialia y rivos vier aostoro into viero) incl. Ma	Time of Injur	Y		
(S) Incident Unly Report	Supervisor's Date	nt Kumuladoo	8 a.m.	Given to Emplo	(D) status	Ohm	
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		RIVIPLO	IYEE INFORMATION		signapamisas aucenas pomes 1811:18	The state of the s	uncanisan procuración de la contraction de la co
Employed's Name (Last, First)	7-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	Home Phon		Cell Ph	0110	Wark Phone	i i i i i i i i i i i i i i i i i i i
Department	Job Titlo (La. Con	todan, Student (ntern)	Podeničaniški sečoja prigijak sektoror proposovo postavoje presidenta	T Ernail		· · · · · · · · · · · · · · · · · · ·	***************************************
Supervisor's Name	Supervise	r's Work Phone	Supervisor's femali	STANDAN GALLONICA COLORO CO	and the state of t	Supervisor's Fex	· And a supplementation of the Selection
Hours Worked Per Week: Da	ys Worked: M-I 2			art time;	O 57117	End Time: 4:30	O e.m.
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Type of Injury	( the stand		PL PO	A A	n Pa	กกก	രവ
Headache 🗐	/////////	$M:\mathbb{N}$	1 18/1/19/	Q = V	N91/109	// WIN (/	
Action Causing Injury	diin	) // T	13		7	141	19
Fumes in building			<b>"</b> 」),	<i>/</i>	( )		·
Contributing Object/Equipment	(411)				1 1	•	1
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Describe in detail how the accident occ	trei (i.a. Frenia	oo was manina a ha	records	lisensel farmatin	- <del>Mariananan</del> 	Parameter same services consistent and services services services services services services services services	~~~
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Sealant used in roof repaire may l	and the second s		***************************************				
Did injury occur on campus? Yes	°° .	Campus location wh	AN accuracy	•	If not on can	ipus, turne & address o	f sike
Nume & contact information of Witness	None E	Was unother person	responsible? Yes	‰ Ø	Were other	amployees lighted?	Yes No Ø O
		Name & contact Info	rmation of responsible		Were Camp	is Police notified?	Yes No
Did the employee miss any work related	to the injury?	NO YES IFW	es, Date: Db-euffe Mohio	Time From:	Ta employ	ce emoip.	**************************************
			land the land of the land		1 0		
Medical Treatment Required		Modical Facility	AL INCOMMATION	organisation of other, please	complete the f	ollowing:	
O None		0	Sharp Rees-Stealy	Physician/Facili	iv Name:		
Offist Aid Officeptualization			Other	Address:	e eath aimmeana		
O Medical Core	,			Phone:			
		- Secon	RECTIVE ACTION		4		
Supervisor's investigation: What action i	will be taken to p	revent recurrence? (	check as many as appr	opriate.	***************************************		
Safety Guidelines Developed	and the same of th	Employee Counse	eled Sofety			ve Equipment Ordered	
Training Schedulad		Repairs Ordered			ther: Displace	ad from PSFA build	lng
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		. Market and the second second second		1		4/4/2019	
Completed By (Print Name)	<del>Yellis de bandal de bandara de la colonia</del>	Signature,			perb.	Date	encine of the second
		*				4/4/19 Rov.	4/23/14

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury
Please fax to 619-594-4013

SAN DIEGO STATE LINIVERSITY SURVEY SHR DON'	· 41811d	Please fai	x to 619-594-41		. Fall Somes	810C VI		
File as:  Worker's Compensation Claim		Date of Injury			e of Injury /w/TH	10 AM- 7 FM	O a.m.	O p.m.
Incident Only Report		Supervisor's Date of	of Knowledge	Dat	a DWC-1 Given to		<del>aragan ing pangan ng /del>	<del>/</del>
Employee's Name (Last, First)		garie J <b>EMPLO</b> Home Phone	YEE INFORMATI	on L	Cell Phone			
Employee's Name (Last, First)		nothe Filone			Cen Phone		Work Phone	•
Department Jo	b Title (i.e. cost	odian, Student Intern)		1	Email	. ^ 1	í	ura (v. 🗪 (v
Supervisor's Name	Supervisor	s Work Phone	Supervisor's Ema	il	**************************************	Superv	sor's Fax	***************************************
Hours Worked Per Week: Days W	Vorked: M-F	S M TOWN		Start tim		l.	ne:	O a.m.
			NT INFORMATIO	in e			7	<b>⊗</b> . p.m.
Injured Body Part UMS		rcle injured part)		BACK	OF HAND injured part)		FRONT OF I	
Type of injury up your cust burning / Hobing eyes			199				My Q	M
Action Causing Injury Furnes: Transcription    Can struction   Can struction	\						True or 1	1
Ventiletan 12		AM	Lo	ft	Right	Lef	t	Right
Describe in detail how the accident occurred  SCALLE YESS 61  The Vantiletian in m  Students exposed	h Pette	ereste fun	- 28, dre - 28, dre - 25 Chulir	1005 1006	anstruction	PSFA.	than Ity	<b>ゴナベドナー</b>
Did injury occur on campus? Yes	No 0	PSFA bu:	re injury occurred		1Chat d	n campus, nar	ne & add ess	of site 1
Name & contact information of Witness:	X L	Vas another person ( Junis Huch In Jame & contact infor	Firm : C	0 0		other employe		Yes No Yes No
Did the employee miss any work related to t	Line in	No Yes If ye		***************************************		······································	·	0 🔯
DIO the employee miss any work related to	ine injuryr	No Yes If ye	is, Oate:	Time I	rom: To:			
Medical Treatment Required		MEDIC Medical Facility	ALINFORMATIC		an a	the following		
None O Emergency Room			Sharp Rees-Steal	v	clan/Facility Name:		•	
O First Ald Hospitalization O Medical Care		O	Other	Addre				
				Phone				
Supervisor's investigation: What action will	be taken to pr		REGITVE/AGITON Theck as many as a		e			
Safety Guidelines Developed		Employee Counse	eled Safety		Personal Pr	otective Equip	ment Ordered	
Training Scheduled		Repairs Ordered			14 Other: Pe	located	<u>L</u>	HILLIAND PHILLIPPIN THE PARTY OF THE PARTY O
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Signaturn



	File as:  Worker's Compensation Claim	Pel 2019 - March	Time of Injury	Ö a.m. O p.m.
	;	Supervisor's Date of Knowledge	Date DWC-1 Given to Empl	
	***************************************			
	Employee's Name (Last, First)	EMPLOYEE INFORMATION Red ID	Priman Ahana	
	Department 1 '>b Title (i.e. ou	stodian, Student Internal	Email	
	- , ,	N. C.	and the second s	n 1
	Supervisor's Name Jupervisor	or's Work Phone Supervisor's Email		
	Hours Worked Per Week: Days Worked: M-F		tart time: a.m.	End Time: O a.m.
		INCIDENT INFORMATION		
	Injured Body Part	(drole Injured part)	BACK OF HAND (circle injured part)	FRONT OF HAND (circle injured part)
	Type of Injury	CIS Lag	0 090	000 000
	a many	Wild Will		I WID WIND
	Action Causing Injury		1000 T	人学体り
	)v8v(		/ \ (	
	Contributing Object/Equipment		***************************************	
	ليالية	8 8 Left	Right	Left . Right
	Describe in detail how the accident occurred (i.e. Emplo			
	many days	dizzino, U	ight head	ed, vomiting
		Campus location where injury occurred	If not on can	npus, name & address of site
	Name & contact information of Witness: None	Was another person responsible? Yes	No.	employees Injured? Yes No
	, and the second se		<i>M</i>	0 0
		Name & contact information of responsible	e part)? Were Camp	us Police notified? Yes No
	Did the employee miss any work related to the injury?	No Yes If yes, Date:	Time From: To:	
	Medical Treatment Required	MEDICAL INFORMATION Medical Facility	· If other, please complete the	fallowing: .
	None CEmergency Room	5harp Rees-Stealy	Physician/Facility Name:	~~~~~~.
i	O Flist Aid O Hospitalization O Medical Care	Other	Address:	
	O medical care		Phone:	
		CORRECTIVE ACTION		
	Supervisor's Investigation: What action will be taken to p	_		, ,
	Safety Guidelines Developed  Training Scheduled	Employee Counseled Safety	١. ٢	ve Equipment Ordered
	1)	Repairs Ordered	Other: INL	2 = C3>10"
	· www.	21.2	, ns	4-30-19
	Completed By (Print Name)	Signature		Date /
	•	· • • · · · · · · · · · · · · · · · · ·		4/30/19 Rev. 4/23/14



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File as:  Worker's Compensation Cla	alm	Date of Injury	pughs	Time of Injury	in. 2019	O a.m.	O p.m.
M Incident Only Report		Supervisor's Date of	Knowledge 500	Date DWC-1	Given to Employee	······································	
			YEE INFORMATION	RANGE W	4119		
Employee's Name (Last, First)	oneggerence (myr	Red ID	IEE INFORMATIO	Primary	Phone Phone	<u> </u>	
Department	Job Title (I.o. Cust	indian, Student Intern)	······································	Email		b <del>onomad</del> i uk	•
	1				-		
Supervisor's Name	Superviso	r's Wark Phone	Supervisor's Email				
	ys Worked: M-F			tart time:	X.3	d Time:	O a.m.
<i>₩</i> +			021X/43/W/61/4V	050304405057	O p.m.	vanico	O p.m.
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Type of Injury	آنيائياً أ	$\int_{A} \int_{A}^{A} \int_{A}^{A$	000			alla	M
coughing			1 Shins		1011/1 <	7.7	حرسا نبرا
Action Causing Injury		~ V ( ] )	(a)			1	1
Gume in PSTA Contributing Object/Equipment	(1)(1)		' '		) ,	<b>,</b> (	1 1
old building		MM	Left		Right	Left	Right
Describe in detail how the accident occ	urred (l.e. Emplo)	yee was opening a bo	x and the box cutter	slipped lacerating	his left thumb.)	* 6.00	
starting at begin		spring sen	nestrev, 201	9, gass	y firmes	m tsta	1.1.67
Coughing videon		Campus location whe	eep Conshi ere injury occurred	550116		s, name & address	
<b>Ø</b>	0	P	STA				
Name & contact information of Witness	s: None	Was another person	responsible? Yes	No A	Were other emp	oloyees injured?	Yes No
•		Name & contact Info	rmation of responsib	le party?	Were Campus P	olice notified?	Yes No
Did the employee miss any work relate	d to the Johny?	No Yes If ye	s. Oate:	Time From:	70:		00
ore the ample that the any training	a an new minute	0 0		***************************************	10.		
		MEDIC	AUNFORMATION				
Medical Treatment Required		Medical Facility	Sharp Rees-Stealy	If other, please	complete the folio	owing:	
O None O Emergency Room O First Aid O Hospitalization		Õ		Physician/Facili	ty Name:		
O Medical Care			,	Address: Phone:			
			Walio de la compa				
Supervisor's investigation; What action		prevent recurrence?			ANTANT UNITED		**0.048.72
Safety Guidelines Developed		Employee Counse	eled Safety	Pe	ersonal Protective	Equipment Ordered	t
Training Scheduled	Д	Repairs Ordered		\$J or	ther: Reli	ocated.	***************************************
Physical Communication (Communication Communication Commun					4.		
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Completed By (Print Name)		Sigu∞				Date	

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Rev. 4/23/14



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# SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS Complete this form in its entirety and submit within 24-hours of the injury Please fax to 619-594-4013

	******											
File as:  Worker's Compensation C	:laim		Jan - Fe	62	019	Time of In	ury /A	m.s O	O p.m.			
incident Only Report			Supervisor's Date	of Knowl		Date DWC	-1 Given to Empl	1 Given to Employee				
	***********	······································		······		•••••••••••••••••••••••••••••••••••••••	411,	·	······································			
Employee's Name (Last, First)	<del>.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</del>	······································	Hame Phone		ORMATION	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	hone :	Work P	hans			
_					_			VVOIR	nane			
Department	Job Title (i.e. Custodian, Student Interp)  Email											
Supervisor's Name		Superviso	r's Work Phone	Superv	isor's Email			Supervisor's Fax				
Hours Worked Per Week: 0	ays Wo	rked: M·F	S M T W	Th i	F. S. I St	art time:	O a.m.	End Time;				
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			*	NT INEC	DRMATION	**************************************	· · · · · · · · · · · · · · · · · · ·	I	9			
Injured Body Part	,		ircle injured part)			BACK OF HA (circle injured pa			OF HAND njured part)			
Type of Injury				<b>\</b> :	8/1/12	A	NI	M	NM			
Action Causing Injury	17	( n ) \	7 41 11	4	( )	100	7 1	21	1,6			
ais funes							/ (	\\_\.				
Contributing Object/Equipment		(1)(1)	(33)		′ ′		, ,	, ,	·			
			AA		Left		Right	Left	Aight			
Describe in detail how the accident occ	urred (i	.e. Employ	ee was opening a box	and the	box cutters	lipped lacerati	ng his left thumb	1				
Fine's causing !	nya d	o etas,	, जे.च्यांतरणः	, 112	U > 181			· <b>''</b>				
Did injury occur on campus? Yes	·	No C	ampus location wher	re injury	occurred	**************************************	If not on cam	pus, name & addr	ess of site			
Ŏ,		<b>O</b>	15PJ									
Name & contact information of Witness	: :	Nous N	Vas another person re	esponsib	le? Yes	No	Wore other a	employees injured?				
		囚		·	Ø'	0		hiotecs militi 401	Yes No			
		N	lame & contact inform	nation o	f responsible	party?	Were Campu	s Police notified?	Yes No			
Oid the employee miss any work related	l to tha	luluni2	1/3/F,1	. D.L.	······································				0 0			
The state of the s	1000	mjaryr	No Yes If yes	s, Date:		Time From:	To:					
			MEDICA	AL INFO	RMATION		***************************************	<del></del>	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~			
Medical Treatment Required		1	Medical Facility			If other, pleas	e complete the fo	ollowing:	***************************************			
None O Emergency Room			Ö.	onarp Re	es-Stealy	Physician/Faci	lity Name:					
OFirst Aid O Hospitalization			O Other			Address:						
Medical Care					1	Phone:						
			CORRI	ECTIVE .	ACTION	······································	·					
Supervisor's Investigation: What action (	will be t	aken to pre	vent recurrence? Ch	eck as m	any as appro	priate.		***************************************				
Safety Guidelines Developed			Employee Counsele	ed Safety	, ,	ПР	ersonal Protectiv	e Equipment Orde	red			
Training Scheduled			Repairs Ordered			( <b>)</b> (1)	ther: Reloca	ated				
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4/8/19

Date



File as:	anti-Marchi al-ris Malis libras communicares meneri	Date of Injury		Time.	of Injury			
O Worker's Compensation Cla	alm	2/27/19		Time C	n injuly		O a.m.	O p.n
<ul> <li>Incident Only Report</li> </ul>		Supervisor's Date of 1/30/19	f Knowledge	øbstell.	by 9.4. Given to Emple	Age		
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Department	Job Title (I,e, cus	todion, Student Intern)	Trickette d	Ema	all	-,,,,-,-,-		
HT'M						•		
Supervisor's Name	Superviso	r's Work Phone	Supervisor's Email		Activistical and activities activities and activities activities and activities activities and activities	Supervis	or's Fax	<del>i de la comp</del> ensada
	ys Worked: M-F	5 M T W		art time:	(a.m.	End Tim	ie:	() a.
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Little at the second second		INCIDE	NT INFORMATION	1				
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Type of Injury	/i*x*i		$[\Omega_{\Omega}]$	P	9 17/9	h	Ma,	UUU
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Action Causing Injury		7 11 x 1	1	17	1	1 CV		سرار ا
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Describe in detail how the accident occurs from the roof work to the Did injury occur on campus? Yes	being done in		een causing hea		and allergy type s	ympton	ns. 18 & address	rsf atto
0		PSFA			W NOT SITE COLUMN	upost nun	is & Midters	OL SKE
Name & contact Information of Witness		Nas another person r	0	No ②	Were other	employee	es injured?	Yes No
(	1	Name & contact infor	mation of responsibl	e party?	Were Campi	us Police i	notified?	Yes N
Did the employee miss any work related	to the injury?	No Yes If ye		Time From	m: To:	······································	***************************************	
		O	e've been	relea	ased ear	ly a fe	we	
		Mebic	AL INFORMATION	Jane 1		1 1 1		
Medical Treatment Required	eternetici itaria sulta bertanti den inter	Medical Facility	1	If other,	please complete the	following		
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O First Aid O Hospitalization		0	Other	Address:	•			
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Physical Co. Let B. 1975 No. 314	411.1	cons	ECTIVE ACTION :				± ·	
Silogivisor's hyestigation What action v	vill be taken to p	'èvent recurrence? Cl	neck as many as appo	ropriate,				William and the state of the st
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Training Scheduled		Repairs Ordered			Wather: Reloc	ate	1 314	119
. * .		(					. / 1	
Canadahad Du (Odalah S)			z	Market Ma	(Married Married Marri	H-7-12-11	1/27/10	<u> </u>
Completed By (Print Name)		Signature	. <i>'</i> .			Date	,	

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